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NEWS RELEASE

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Concerned about reform's impact, employers accelerate efforts to bring health benefit costs under control

- New survey finds that employers added consumer-directed plans in record numbers in 2011 and added incentives to build employee participation in wellness programs.
- Overall health benefit cost rose 6.1% in 2011, down from 6.9% in 2010, with a still lower increase predicted for 2012.
- Reform law's excise tax for high-cost plans remains employers' #1 health reform concern.
- Still, most employers believe they will continue to offer coverage after state exchanges come online in 2014.

New England, November 16, 2011 at 10 a.m. EST
Against the backdrop of uncertainty created by health reform, employers are accelerating their efforts to bring health benefit cost under control. According to the National Survey of Employer-Sponsored Health Plans, conducted annually by Mercer and released today, growth in the average total health benefit cost per employee, which had reached 6.9% last year, slowed in 2011 to 6.1%, with an increase of 5.7% expected for 2012 (Fig. 1). Cost averaged $10,146 per employee in 2011 (Fig. 2).

Mercer's nationally projectable annual survey includes public and private organizations with 10 or more employees; 2,844 employers responded in 2011.

"In a tough economy where high benefit cost increases often have to be balanced with lower pay increases, cost management is already important," said Gary Hartnett, a principal in Mercer's Hartford office. "But given the new cost pressure from health reform, for many employers it's becoming an imperative."

One provision of the Patient Protection and Affordable Care Act (PPACA) that went into effect in 2011 was a requirement that employers extend dependent coverage eligibility to employees' children up to age 26. Health plan enrollment grew by an average of 2% in 2011 as a result. Provisions going into effect in 2014 include requiring employers to extend coverage eligibility to all employees working at least 30 hours per week on average and auto-enrolling newly eligible employees. Employers expect that these provisions – along with the new mandate that all individuals obtain health insurance coverage – will result in another increase in enrollment. Retailers and other employers with large part-time populations are likely to be the most affected.

Still, the provision that concerns the most employers is the excise tax on high-cost plans[*] – nearly half say it's a "significant" or "very significant" concern (Fig. 3). While some employers offer high-cost plans because generous benefits are part of their attraction and retention strategy, others have high-cost plans simply because they have an older or less healthy workforce or are located in a high-cost area. Only 39% of employers with 50 or more employees believe their current plans won't hit the excise tax cost threshold, which will be tied to CPI and increase each year.

Nearly all the rest are determined to avoid the tax if they can: 21% say they "will do whatever is necessary to bring cost below the threshold amounts," and 36% say they will attempt to bring the cost below the threshold amounts, acknowledging that "it may not be possible." Only 4% will take no action to avoid the tax.

"Employers that are concerned about a jump in enrollment in 2014 or the excise tax in 2018 see a need to slow cost growth now," said Mr. Hartnett. "While cost-shifting to employees is still going on, this year we saw more employers adopting strategies they believe will provide better results over the long haul."

Just under half of all employers (47%) say they will shift cost in 2012 by raising deductibles or the percentage of the premium paid by employees. This is down slightly from 50% saying they would shift cost in 2011.

Employers add consumer-directed plans

This year saw the biggest increase ever in the adoption of high-deductible, account-based consumer-directed health plans (CDHPs) by large organizations. Now, 32% of all employers with 500 or more employees offer a CDHP, up sharply from 23% in 2010 (Fig. 4). The largest employers are the most likely to offer a CDHP (47% of those with 10,000 or more employees do so), but CDHP use grew among small employers as well, from 16% to 20%.

Overall, 13% of all covered employees are enrolled in a CDHP. Enrollment growth has been rapid – five years ago, CDHPs enrolled just 3% of covered employees.

The appeal of these plans to employers is clear. The cost of coverage in a CDHP with a health savings account is nearly 20% lower, on average, than the cost of PPO coverage – $7,787 per employee compared to $9,385 (Fig. 5).

In addition, some employers see these plans as integral to strategies to improve workforce health. "One feature of the CDHP that employers like is flexibility in funding employees' spending accounts," said Mr. Hartnett. "A growing number of employers are making their account contributions contingent on the employees' willingness to take steps to improve their own health."

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[*] Starting in 2018, health benefit coverage that costs more than $10,200 for an individual employee or $27,500 for dependent coverage will be subject to a 40% excise tax.

Employers put teeth into health management programs with incentives – and penalties

Workforce health management, or "wellness", has emerged as employers' top long-term strategy for controlling health spending. When asked about a long-term response to the changes initiated by health reform, an astonishing 87% of large employers say they will add or strengthen programs or policies to encourage more health-conscious behavior.

In 2011 it was clear these efforts were well underway. For a second year in a row there was a sharp increase in the use of incentives or penalties to encourage higher participation rates: 33% of large employers with health management programs provided incentives or penalties, up from 27% last year and 21% in 2009 (Fig. 6).

In addition, the incentives are becoming more substantial. Five years ago, the most common incentive offered by large employers for completing a health assessment was either a token gift or cash; this year it is a lower premium contribution (the median reduction in the annual contribution is $240).

Health assessments, which are intended to alert employees to possible health risks and to identify individuals who could benefit from disease or lifestyle management programs, are offered by most large employers (70%), but small employers are adopting them as well: 34% offered an assessment in 2011, up from 29% in 2010.

A year after PPACA, most employers still say it's unlikely they will drop health plans

Despite employers' concerns about the impact of reform, when asked how likely they are to terminate their health care plans after state-run insurance exchanges become operational, the great majority says "not likely." Large employers in particular remain committed to their role of health plan sponsor. Just 9% of all employers with 500 or more employees – 4% of those with 5,000 or more employees – say they are likely to terminate their health plan and have employees seek coverage in the individual market after 2014 (Fig. 7).

"Employers have had a year to think about the impact of health reform," said Mr. Hartnett. "When they consider the penalty, the loss of tax savings and potentially grossing up employee income so they can purchase comparable coverage through an exchange, many don't see a financial advantage in dropping coverage."

A greater portion of small employers say they are likely to terminate their plans: 19% of those with 10-499 employees, essentially unchanged from 20% in 2010. Employers of this size are less likely to offer coverage to begin with; they generally offer fully insured health plans and, with small risk pools and little purchasing power, are vulnerable to large rate increases. In 2011, the percentage of small employers offering an employee health plan fell from 57% to 53%.

"Best practices" save money

Large employers reported a significantly lower average health benefit cost increase than small employers in 2011: 3.6% compared to 9.9%. "The health care reform law may have had a greater

impact on small employers than large employers in 2011," said Mr. Hartnett. "But the survey also shows that large employers are doing more to control health benefit cost."

Small employers tend to offer less-generous coverage than large employers, and so were more likely to be affected by new PPACA rules restricting annual benefit limitations and mandating free preventive care. However, they are also less likely to invest in the types of programs that large employers are using to manage cost.

Mercer's survey asks employers about more than 20 "best practices" in managing health plans – strategies intended to control cost, such as providing incentives to improve health habits or contracting with smaller, high-quality, cost-efficient provider networks. When large employers were divided into three roughly equal groups based on the number of best practices they have incorporated, the average per-employee medical plan cost was 7% higher for those using no more than six best practices compared to those using 10 or more. The average cost of the health benefit program as a percentage of payroll was higher as well in the group using fewer best practices – 16% compared to 14% (Fig. 8).

"What's exciting about this analysis is that it shows that effective tools exist to hold health care cost in check – and that it's not all about shifting cost to employees," said Mr. Hartnett.

Other findings

- **Significant drop in offerings of medical plans for Medicare-eligible retirees** The prevalence of retiree medical plans slid to its lowest point ever in 2011, with just 24% of large employers offering a plan to retirees under age 65 and just 16% offering a plan to Medicare-eligible employees – down from 25% and 19%, respectively (Fig. 9). However, some employers that stopped offering a plan for which new hires are eligible continue to offer coverage to employees retiring or hired after a specific date; an additional 15% of all large employers offer coverage to such a closed group.

- **Domestic partner coverage** Close to half of large employers include same-sex domestic partners as eligible dependents – 46%, up sharply from 39% in 2010. This varies significantly based on geographic region, from 79% of employers in the west to 28% of employers in the south.

- **Spousal surcharges** 15% of large employers have special provisions concerning spouses of employees with other coverage available – 7% impose a surcharge and 7% do not provide coverage at all.

- **Annual prescription drug cost increase** slowed to just 5% in 2011, down from 10% five years ago and 17% ten years ago, as employers have implemented strategies to encourage the use of generic and over-the-counter drugs.

- **Move to self-funding?** Concerns that new PPACA regulations will drive up the cost of fully insured plans has sparked greater interest in self-funding. Of the 28% of employers with 500 or more employees that have a fully insured PPO, one-third say they are likely to switch to self-funding within the next three years. Just 8% of smaller employers say it's likely they will switch.

- **Grandfathered status** Only about half of all employers (and 37% of large employers) believe they will maintain the grandfathered status of all their health plans until 2014. One-third had no grandfathered plans in 2011 and 18% expect to lose grandfathered status over the next two years.

Survey methodology

The Mercer *National Survey of Employer-Sponsored Health Plans* is conducted using a national probability sample of public and private employers with at least 10 employees; 2,844 employers completed the survey in 2011. The survey was conducted during the late summer, when most employers have a good fix on their costs for the current year. Results represent about 800,000 employers and more than 104 million full- and part-time employees. The error range is +/–3%.

The full report on the Mercer survey, including a separate appendix of tables of responses broken out by employer size, region and industry, will be published in late March 2012. The report costs $600 and the report and tables cost $1,200. For more information, visit www.mercer.com/ushealthplansurvey or call Tara Lewis at 212/345-2451.

Notes for editors

Health maintenance organizations (HMOs) use a network of health care providers and do not cover care provided outside of the network.

Preferred provider organizations (PPOs) utilize a network of providers. There may be incentives for members to use the network providers, but they are covered for care received outside the network. **Point-of-service plans** are included.

A **consumer-directed health plan (CDHP)** is a medical benefit design in which employees use spending accounts – **Health Savings Accounts (HSAs)** or **Health Reimbursement Arrangements (HRAs)** – to purchase routine health care services directly. Non-routine expenses are covered by traditional insurance after members meet a generally high deductible. Online health and financial tools are generally provided. With an HSA, employees may contribute pre-tax dollars into the account; an employer contribution is optional, but employees have full control over all money in the account. With an HRA, only employers may fund the account and they decide whether money left in the account at the end of the year may roll over.

About Mercer

Mercer is a global leader in human resource consulting, outsourcing and investment services. Mercer works with clients to solve their most complex benefit and human capital issues by

designing, implementing and administering health, retirement and other benefit programs. Mercer's investment services include investment consulting, implemented consulting and multi-manager investment management. Mercer's 20,000 employees are based in more than 40 countries. The company is a wholly owned subsidiary of Marsh & McLennan Companies, Inc., which lists its stock (ticker symbol: MMC) on the New York and Chicago stock exchanges. For more information, visit www.mercer.com.

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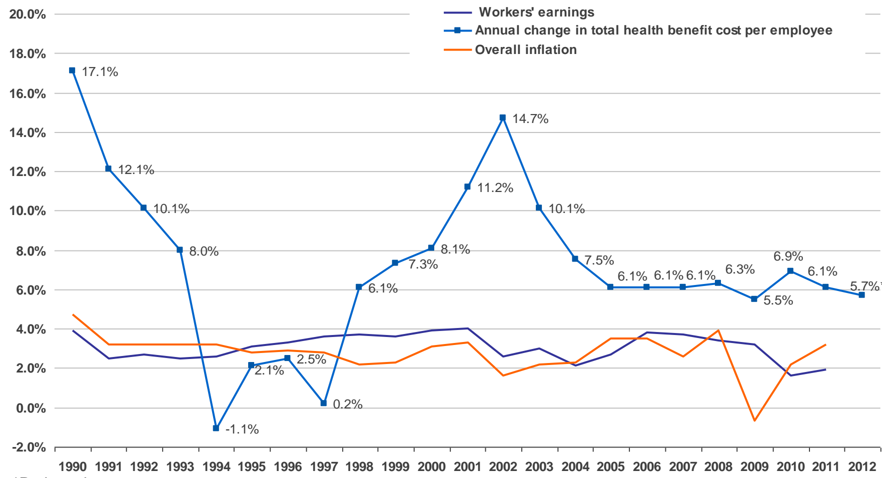
New York, November 16, 2011 at 10 a.m. EST

FIGURE 1

Growth in total health benefit cost per employee slows to 6.1% in 2011 with a 5.7% increase expected for 2012



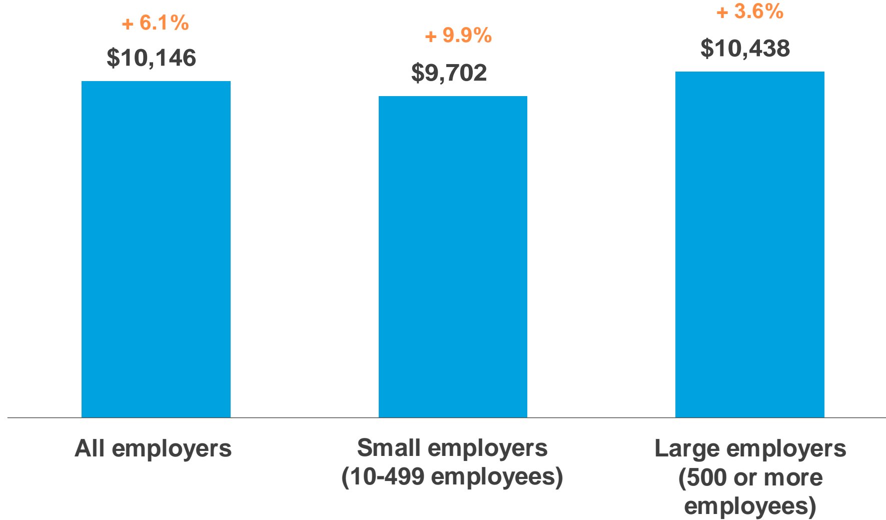
*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2010.

FIGURE 2

Average cost tops $10,000 per employee

Total health benefit cost per employee in 2011, by employer size

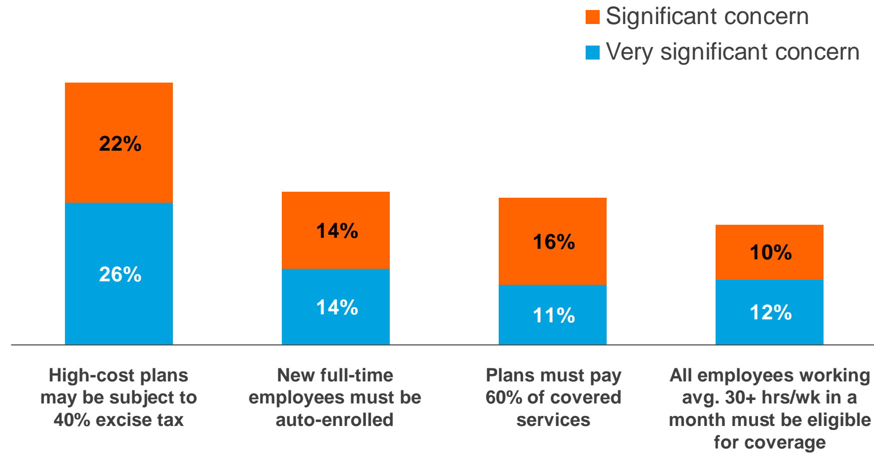


Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 3

Employers fear additional cost pressures as new PPACA provisions kick in

Level of concern regarding PPACA provisions, given potential impact on cost, administrative burden or employee relations



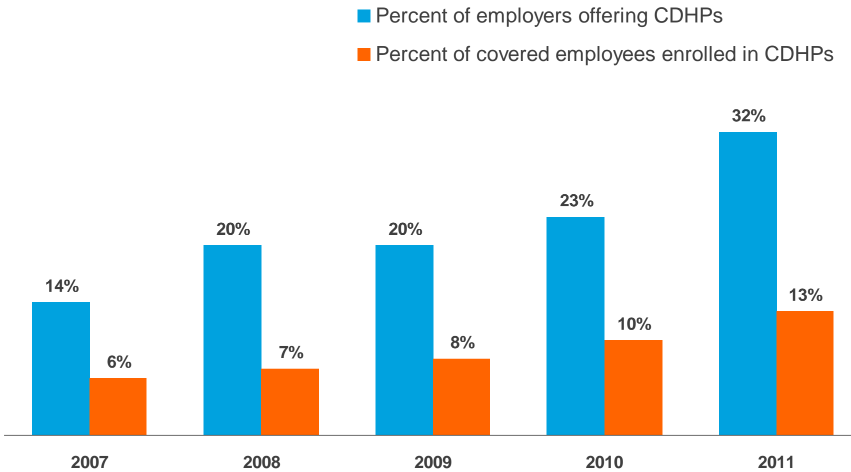
Data based on employers with 50+ employees.

Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 4

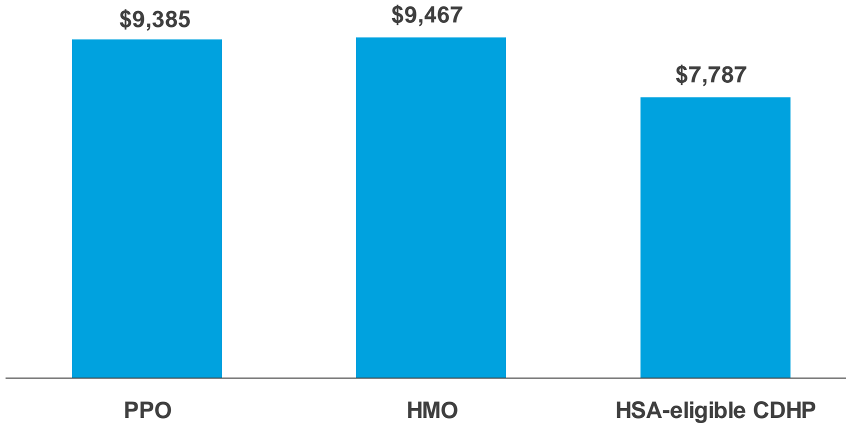
Sharp increase in CDHP offerings among large employers in 2011

Percent of employers with 500 or more employees



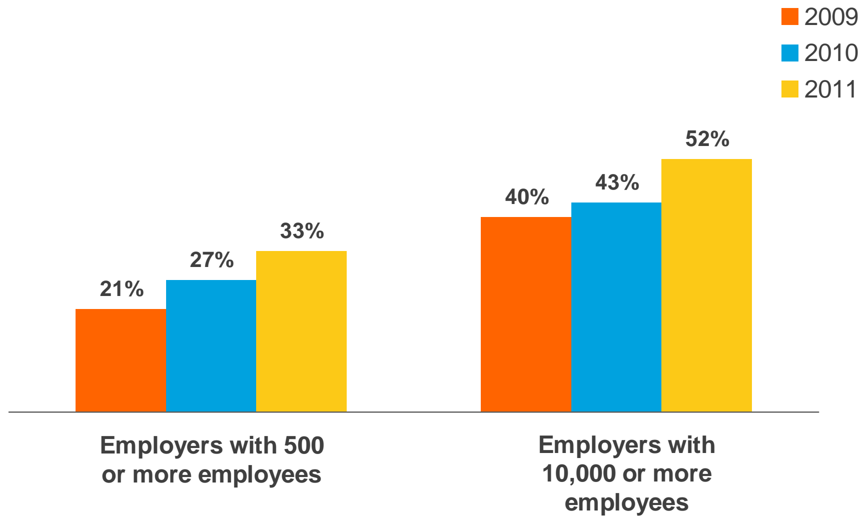
Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 5
HSA-based CDHPs cost nearly 20% less than other medical plan types in 2011
Medical plan cost per employee (includes employer contributions to HSA accounts)



Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 6
Employers add incentives and penalties to boost employee participation in wellness or health management programs



Source: Mercer's National Survey of Employer-Sponsored Health Plans

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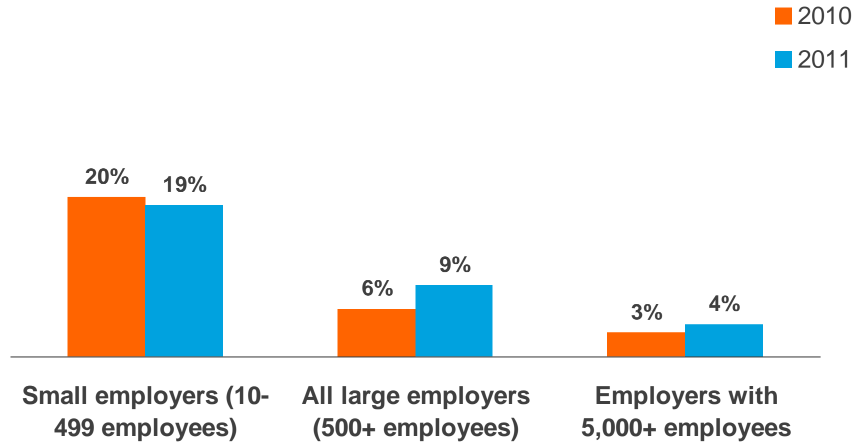
New York, November 16, 2011 at 10 a.m. EST

FIGURE 7

A year after PPACA, most employers remain committed to offering health coverage

Percent of employers that say they are "very likely" or "likely" to terminate plans after state insurance exchanges become operational



Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 8

Mercer analyzed respondents' cost based on their use of cost-management best practices

- Contribution for family coverage in primary plan is at least 20% of premium
- Four or more employee contribution tiers
- PPO in-network deductible is $300 or more
- PPO plan has higher cost-sharing for specialists
- Offer a CDHP
- Make contribution to an HSA
- Rx mail-order copay is at least 2.5x retail copay
- Part of an Rx purchasing coalition

- Spousal surcharge
- Smoker surcharge
- Offer optional HM services through plan or vendor
- Use incentives for HM programs
- Use incentives for health status targets
- Offer an EAP
- Voluntary benefits integrated with core benefits
- High-performance networks
- Data warehousing
- Collective purchasing

- Value-based design
- On-site clinic
- One or more Rx strategies (i.e. mandatory generics)
- One or more specialty drug provisions (i.e., step therapy)
- One or more health plan innovations:
  - –Surgical centers of excellence
  - –Retail clinics
  - –Telemediated care
  - –Medical homes

Source: Mercer's National Survey of Employer-Sponsored Health Plans

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FIGURE 8, continued

Early analysis suggests that employers are controlling cost through use of best practices

Large employers

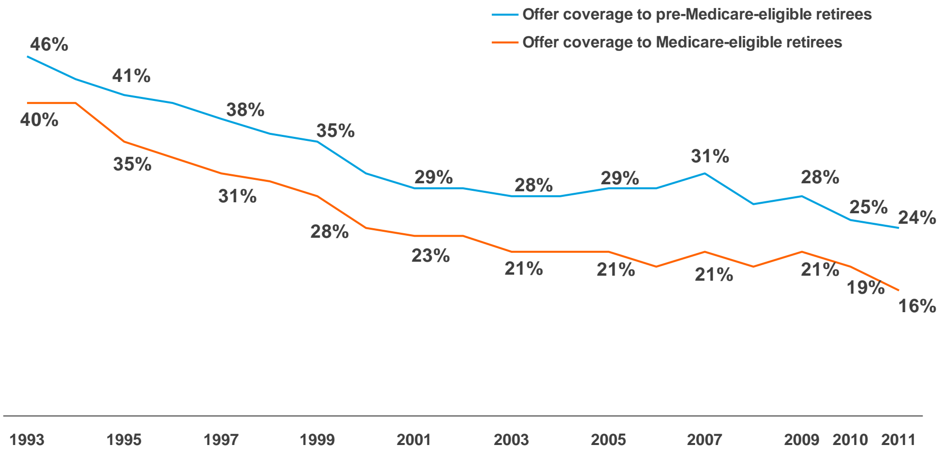
	Total health plan cost per employee	Cost of health benefit programs as a percent of payroll
Use 6 or fewer best practices	$10,700	16%
Use 10 or more best practices	$10,045	14%

Source: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 9

Offerings of medical plans* for Medicare-eligible retirees drop to just 16% of large employers, a new low

Percent of large employers



*Plan must be offered on an ongoing basis (i.e., new hires are eligible).

Source: Mercer's National Survey of Employer-Sponsored Health Plans